Laurie Ferguson, Psy.D.
Licensed Clinical Psychologist, Director
Spark Psychological Services
Laurie Ferguson, Psychologist, Inc.
5975 Entrada Ave. • Atascadero, CA • 93422
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Information Regarding Office Policies and Fees
Welcome to the practice! Please let me know if you have any questions!

COVID19 Notice: To keep everyone healthy, most appointments are conducted via confidential, HIPAA-secure teletherapy (Zoom) when possible. This may limit the effectiveness of therapy or assessment, and additional in-person therapy or assessment may be needed, if desired. Please let Dr. Ferguson know what you prefer.

Cancellation Policy: Appointments are made for you only (I do not "double book" appointments). Please call or email with at least 24-hour notice to reschedule or cancel an appointment. Special circumstances sometimes occur where 24-hour notice may not be possible. To keep all our patients healthy, please reschedule your appointment if you are ill. **If illness or special circumstances do not apply, you will be billed for a missed session.** If you are more than 15 minutes late, you will need to reschedule and you will be billed for the missed session. If too many sessions are missed, or if this appointment policy is being abused, termination of services may occur.

Your Appointment, Fees and Insurance: Dr. Ferguson is an out-of-network provider for your insurance. You are responsible for covering the fee at the time of service. You will be provided a Super Bill to submit to your insurance. Contact the insurance company prior to your appointment to verify any out-of-network benefits. Personal checks, cash, credit and debit cards, and Health Care Savings Account credit/debit cards are accepted.

In shared child custody arrangements, the parent bringing the child for treatment is responsible for payment. In shared custody arrangements, both parents must sign this form and consent for treatment.

For TCRC, Social Security, Social Services, School/College clients: An assessment by Dr. Ferguson is no guarantee of eligibility or services, which are at the sole discretion of the agency/organization. Assessment results could result in an increase or decrease of services or denial of eligibility, even if you already are eligible.

Dr. Ferguson does not accept Medicare, and her services are not reimbursable by Medicare. If you are a Medicare client or are Medicare-eligible, you must advise Dr. Ferguson. You must complete a separate contract mandated by Medicare prior to your appointment if you have Medicare or are Medicare-eligible.

Fee Schedule (with CPT codes): *fees are subject to change without notice*
Consultation, Intake Appointment and/or Diagnostic Interview (90791), 60 minutes, $250
Psychological Testing (96130, 96131, 9613, 96137), 60 minutes, $250
Individual Therapy (90834) or Family Therapy (90846 / 90847) 45-50 minutes, $160 or 60 minutes (90837) $175
Expert Witness Services or any court-related services, 60 minutes, $500 ($3,000 retainer required)
Brief phone call or email to change appointments, no charge
All other phone calls, emails, reports, and meetings attended are pro-rated for actual time spent by Dr. Ferguson

Late Payments: Payment is due at the time of service. There is a $35 fee for returned checks. A late fee of $25 per month is applied to past due accounts. Unpaid account balances over 30 days may be forwarded to collections and termination from the practice may occur.

What can I expect in therapy or testing? What do I tell my family member about the appointment? You know yourself the best, and you have the right to set your own goals and pace. Dr. Ferguson will inform you whether your goals are compatible with her services. How long therapy or testing takes will depend on your goals, symptom severity, and other factors. Therapy and testing are ways to know more about your learning style,

emotions, thoughts, and behaviors, so that you can succeed at school, work, and in relationships. Difficult topics are discussed and some people experience an increase in depression, anxiety, unsafe behavior, or even suicide. It is very important that you share this with Dr. Ferguson so that she can help you. For testing clients, you have a right to receive a report of Dr. Ferguson's findings in understandable language. You have a right to disagree with Dr. Ferguson's recommendations or diagnoses. Dr. Ferguson welcomes your questions and feedback, and this can improve the effectiveness of the therapy or accuracy of the assessment. You have a right to terminate therapy at any time. It is always helpful to discuss this with Dr. Ferguson so that she can give you referrals if needed.

Privacy and Confidentiality: Your privacy is very important to Dr. Ferguson. As this is a small community, we may occasionally see each other outside of our appointment. In order to protect your privacy, it is up to you if you would like to say hello or communicate in any way. I do not participate in fundraising or business endeavors of my clients. Your Personal Health Information (PHI) is protected by the Health Insurance Portability and Accountability Act (HIPAA: www.hhs.gov.). Your private information is never shared without your written authorization, or as permitted by law, including but not limited to the following:

If child or elder abuse or neglect occurs, or if a client is a danger to him- or herself or others, Dr. Ferguson is required by law to disclose this information and client contact information to the proper authorities.

In any judicial matters, confidentiality ends when a judge issues a court order for my records or if you bring a lawsuit or licensing board complaint against Dr. Ferguson.

Minor clients: Only parents/guardians with legal custody for health care decisions have access to a minor's records, regardless of who is paying for the session. Dr. Ferguson is legally prevented from releasing information to parents without the minor's consent, including information regarding pregnancy, drug or alcohol use, contraceptive use, sexually transmitted diseases, or medical history.

Contacting You: You will be asked in the Client Intake Form how you would like to be contacted for confidential messages. All information and appointment requests need to be communicated in voicemail or email. Dr. Ferguson cannot respond by text. Use of email means that you accept the risk of electronic communication. There is no guarantee that information in an email or attached to an email remains private. This includes but is not limited to encrypted information, "secure" email services such as Gmail, or cloud-storage services such as Drop-Box.

Social Media: To help protect your confidentiality and preserve therapeutic boundaries, I do not "friend," follow, or search clients online. If you happen to receive a "friend" request from me, it is an error (please contact me to let me know). Posting a review of my services is your right, but to protect your confidentiality, I will not respond online. I welcome any comments about our work and hope we can communicate in person. I maintain two professional media services (Twitter and a Facebook page), which you are welcome to follow for psychology-related articles and information. Following my professional media accounts is not an endorsement of my services.

Emergency Information: Dr. Ferguson does not provide emergency services. If you are experiencing a life threatening emergency, call 911 or go to your nearest emergency room. Mobile Crisis can be called for non-life threatening services 24 hours, 7 days per week at 800-838-1381. The SLO Hotline is also available 24 days, 7 days per week for resources and suicide prevention at 800-783-0607.

I have received and understand the above Information regarding Policies and Fees.

Printed name of patient	Signature of patient (only needed if age 18+)	Date
Printed name of parent/guardian	Signature of parent/guardian	Date

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CLIENT INTAKE INFORMATION

The Client is the person coming for therapy, assessment, support, or consultation

This information is very helpful in supporting and/or evaluating the client. This information may be included in a written report, unless you advise Dr. Ferguson otherwise. Any information shared with Dr. Ferguson, either written or verbal, may be subject to court subpoena, therefore, there are limits to confidentiality.

Client's full legal name: _____ Today's date: _____

What name do you prefer to be called? _____ Date of birth: _____

Age: _____ Gender: _____ Pronouns: _____ Who referred you? _____

Home street address: _____ City: _____

State: _____ Zip: _____ Ethnicity / Religion: _____

Profession: _____ Employer: _____ City: _____

If Client is a minor (under age 18) or a conserved adult: Is the client a conserved adult? ❑ Yes ❑ No
What is the relationship between the client and their guardian: _____
Who has legal custody for health care decisions? (this is different than physical custody): _____

Emergency Contacts (or Parent / Guardian if Client is a minor or conserved adult)

#1 Name: _____ Address: _____

Employer: _____ Occupation: _____

#2 Name: _____ Address: _____

Employer: _____ Occupation: _____

Contacting you: Check the YES box if it is ok to leave confidential information. Check the NO box and only Dr. Ferguson's name and phone number will be left in messages. By checking "Yes," you agree to accept the risks of electronic communication that is not guaranteed secure.

Is it ok to leave confidential information?

Client's (or Parent's if a minor) Home Phone: _____ ❑ Yes ❑ No

Client's (or Parent's) Cell: _____ ❑ Yes ❑ No

Alternate Phone: _____ ❑ Yes ❑ No

Email: _____ ❑ Yes ❑ No

If you are here for an assessment, choose the way(s) you would like your report sent to you:
❑ Email ❑ Regular Mail ❑ Fax: _____

Current or Last School Attended: _____
City: _____ What year in school is the client or highest degree/year achieved: _____
Has the Client ever had any of the following: ❑ 504 Plan ❑ IEP ❑ SST ❑ Special Education ❑ Audiology ❑ Psychoeducational or Psychological Testing ❑ Occupational Therapy ❑ Physical Therapy ❑ Vision Therapy ❑ Speech/Language Eval/Services ❑ Neurology ❑ Regional Center ❑ Tutoring ❑College Disability Supports ❑ ADA Accommodations at work ❑ Other: _____

Current Medical Concerns & Medications:_____
_____
_____
_____
_____

Physician/Pediatrician's name: _____ City: _____
Therapies, past and current: Provider Name / Purpose / Dates: _____
_____
_____
_____
_____

Who Lives With The Client?: Client's Marital Status: _____
Household Members: (Name / Relationship / Age / Does this person live with the client full-time?)
_____
_____
_____
_____

What are your main concerns?_____
_____
_____
_____
_____

What are your goal(s) for therapy / assessment?_____
_____
_____
_____
_____

Primary language(s) / Does the client require an interpreter?: _____
Does the client uses assistive technology (AAC device, wheelchair, etc.): _____
_____

How can Dr. Ferguson make your appointment more comfortable and accessible? (sensory needs, breaks, written communication during our sessions, etc.) _____
_____
_____

Limitations on services: *Please note that if the client has been involved in, or anticipates being involved in, child custody matters, a worker's compensation claim, arrest/probation, or other legal matters, it is important that you work with a therapist or evaluator who specializes in these areas to protect your legal rights. Dr. Ferguson's services are not designed to support clients with these concerns. By signing below, you acknowledge these limitations to Dr. Ferguson's services.*

Client's Signature: _____ Date:_____

Parent's or Guardian's Signature (if applicable): _____ Date:_____

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SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

This information is very helpful in supporting and/or evaluating the client. This information may be included in a written report, unless you advise Dr. Ferguson otherwise. Any information shared with Dr. Ferguson, either written or verbal, may be subject to court subpoena, therefore, there are limits to confidentiality.

GENERAL INFORMATION: *The Client is the person coming for therapy, assessment, or support*

Client's full legal name_____ DOB_____
Primary language(s) / Does the client require an interpreter?:_____
The client uses assistive technology (AAC device, wheelchair, etc.): _____

Have there been any significant stresses / changes in the client's life? How has the client adjusted to this?
(marriage, deaths, births, moves, work changes, divorce, traumatic experiences, etc.)_____

Client's strengths and interests:_____

EDUCATIONAL HISTORY:

Briefly describe client's academic performance, behavior, social factors, and any concerns:
Preschool/Daycare_____
Elementary School_____
Middle School_____
High School _____
College _____

How motivated is / was the client is to learn? _____
Homework was / is usually: □ Not a struggle □ Sometimes a struggle □ Often struggles
Excessive absences or tardies in school? □ No □ Yes_____
Behavior problems at school? □ No □ Yes _____

Are there services/supports you would like the school/college to provide: □ additional time on tests
□ quiet room for tests □ help with organization or study skills □ note taking help □ aide in the classroom (K-12)
Other: _____

WORK HISTORY □ The client does not have job experience / employment
Current or Latest Employer: _____Position Title: _____
Length of time at current job: _____ Does the client enjoy the job? □ Yes □ No
How motivated is the client is to meet the job responsibilities? _____
Is work difficult for the client? □ Not a struggle □ Sometimes a struggle □ Often struggles Why? _____
_____
Has the client experienced discrimination on the job? □ Yes □ No Describe: _____
_____
Are there accommodations you would like the employer to provide: □ work from home □ modified schedule
□ time to sit down □ breaks □ clearer instructions □ visual schedule Other: _____
_____
_____
Is the client paid adequately? □ Yes □ No Does the client wish to change jobs? □ Yes □ No
Does the job change require going back to school or getting more training? □ Yes □ No
List any skills that the client needs to develop in order to be more successful at work: _____
_____

INDEPENDENT LIVING SKILLS: Please check below all skills that **the client can do independently (without excessive reminders or excessive support for the client's age):** □ No concerns for independent living

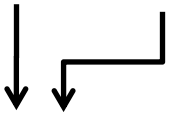
□ Dressing / undressing
□ Showering, bathing, wash face, brush teeth
□ Getting/fixing a simple snack
□ Understands concept of stranger danger
□ Bathing, dressing, grooming
□ Grocery Shopping
□ Cooking a whole meal
□ Cleaning the kitchen or bathroom
□ Doing a load of laundry
□ Attend college, trade school, or training
□ Live in a dorm or with roommates
□ Live on his/her own
□ Drives a car (or is learning to drive)
□ Using public transportation for a long trip
□ Applying for a credit card
□ Applying for a job and interviewing
□ Quick learner
□ Keeping room clean, putting away belongings
□ Completing chores or responsibilities
□ Stays w/ caregiver in public (does not wander off)
□ Understands how money works and how to save
□ Ride a bus, walk or bike in the community
□ Comfortable talking with adults
□ Understands social media risks
□ Can make own doctor or other appointments
□ Can open own savings or checking account
□ Can keep to a budget and not overspend
□ Understands how marketing influences buying choices
□ Understands how to avoid possible dangerous situations
□ Is not easily taken advantage of
□ Knows how to choose friends
□ Has good coping skills, is resilient
□ Can resolve disagreements w/ peers or co-workers
□ Hard worker

Other concerns with independent living: _____
_____

CLIENT'S HEALTH: How is the client's health now? □ Excellent □ Good □ Fair □ Poor
When was last check-up? _____ Are vaccines up to date? □Yes □ No: _____
Any vaccines the client will skip or can't have? □ No □ Yes: _____
Any concerns with growth/weight/nutrition? □ No □ Yes: _____
Drug/alcohol use: □ Nicotine □ Alcohol □ Marijuana □ Vape □ Other / How often: _____
Any sleep problems currently? □ Trouble falling asleep □ Waking up too early and can't get back to sleep
□ Nightmares □ Sleepwalking □ Night terrors □ Restless sleep □ Tired even after sleeping "enough" hours
What time does the client go to sleep? _____ Wake up?_____ □ Sleep times are inconsistent
Any concerns with adequate exercise? _____

Client's Medical Conditions: Has the client had any of the following? (There is space later to discuss family history.) Include when this was an issue (example: migraines age 14-25; thyroid condition age 18-present).

Past Month **Not a concern now But client has a history of this**



□ □ Headache _____
□ □ Migraine _____
□ □ Head injury_____
□ □ Seizures _____
□ □ Blackouts or fainting _____
□ □ Surgery _____
□ □ Hospitalization (overnight) _____
□ □ ER visit(s) _____
□ □ Ear Infections_____
□ □ Allergies to foods, medications or seasonal allergies _____
□ □ Asthma _____
□ □ Wears glasses _____
□ □ Hearing Problems _____
□ □ Constipation or Diarrhea _____
□ □ Other Gastrointestinal Problems _____
□ □ Thyroid Condition _____
□ □ Heart Condition _____
□ □ Skin Conditions _____
□ □ Hormone Therapy_____
□ □ Physical, Sexual, or Emotional Abuse _____
□ □ Poverty, Homelessness, Food Insecurity or Neglect_____
□ □ Other concern (please describe) _____
□ □ There is health care, surgery, or procedure that the client needs/wants but has not been able to access it: __
_____

Any additional health information: _____
_____

BIOLOGICAL FAMILY MEMBERS' HISTORY:

Highest education level achieved by biological mother: □ some high school □ GED □ high school grad □ some college □ 4-year college degree □ master's degree □ doctorate degree □ trade school □ other: _____

Highest education level achieved by biological father: □ some high school □ GED □ high school grad □ some college □ 4-year college degree □ master's degree □ doctorate degree □ trade school □ other: _____

Biological family members (parent, sibling, aunt/uncle, grandparent, cousin, etc.) have experienced:
□ Learning Difficulties _____
□ Formally diagnosed with Dyslexia / Reading Disorder _____
□ Formally diagnosed with Learning Disorder in math _____
□ Formally diagnosed with Learning Disorder in writing _____
□ Attention problems _____
□ Hyperactivity _____
□ Formally diagnosed with ADD or ADHD _____

Biological family members (parent, sibling, aunt/uncle, grandparent, cousin, etc.) have experienced (con't):

□ Speech or Language problem _____
□ Diagnosed or suspected (circle) Autism _____
□ Diagnosed or suspected (circle) Asperger's _____
□ Intellectual Disability or Cognitive Delay_____
□ Depression _____
□ Anxiety or Panic (circle) _____
□ Obsessive Compulsive symptoms _____
□ Hoarding _____
□ Mood Swings _____
□ Formally diagnosed with Bipolar Disorder _____
□ Excessive anger or rage _____
□ Schizophrenia _____
□ Drug or alcohol problem _____
□ Other concern: _____

CLIENT'S DEVELOPMENT:

Pregnancy of Client's Biological Mother: Biological mother's age at birth? _____
Did mother receive routine medical prenatal care? □Yes □ No When did prenatal care start? _____
Any medications used during pregnancy?: _____
During pregnancy was there any use of: □ nicotine/cigarettes □ marijuana □ illegal drugs □ other: _____
Were fertility treatments utilized for this pregnancy?: _____
Child was born at City/State: _____ □ home □ hospital □ birthing center
Pregnancy was □ full term □ other: _____weeks / months
Child's birth weight: _____pounds _____ounces APGAR score at 1 minute____ at 5 minutes_____ □ unknown

Mother's pregnancy	Child's Delivery	Child's Condition at Birth
□ No complications	□ Normal	□ Normal
□ Diabetes	□ Induced labor	□ Breathing problem
□ Injury	□ C-section	□ Jaundice
□ Hypertension	□ Breech birth	□ Birth injury/defect
□ Excessive bleeding	□ Very long labor (>12 hours)	□ Newborn ICU
□ Emotional stress	□ Other problem (specify):	□ Other problem (specify):
□ Other problem (specify)	_____	_____

Client's behavior as an infant and toddler (up to 3 years of age – there is space later to discuss concerns that occurred when older): Were any of the following a significant concern?

□ Difficult to comfort
□ Excessive irritability
□ Colicky
□ Did not sleep very much
□ Needed very specific things to sleep (movement, only slept in a sling, etc.)
□ Repetitive behaviors
□ Self-injurious behaviors
□ Eye contact was different than expected
□ Did not respond to speech of caregivers
□ Concerned about hearing problems
□ Difficult nursing
□ Difficulty transitioning to baby food or table food
□ Did not want to be alone much at all
□ Did not mind or preferred being alone

Describe concerns with pregnancy, delivery, temperament as a newborn (happy, "easy," "colicky," etc.):

_____

_____

Development of Client: Please indicate approximate age when the client reached the following milestones:

□ Not sure about ages, but milestones were probably met within typical timeframes

Age sat up without help:_____
Age walked alone: _____
Age spoke first words: _____
Age spoke short phrases: _____
Age spoke in sentences:_____

Age bladder trained for day:_____
Age fully bowel trained:_____
Age stayed dry all night: _____
Age when there were no longer any concerns with toileting or accidents: _____

Communication and Motor Skills: Did/does the client have *more difficulties than most other people of the same age with any of the following, or does the client engage in the behaviors more often than others the same age:*

Past Month	**Up to age 5 or 6 years old**	**Past Month**	**Up to age 5 or 6 years old**
□	□ Eye-hand coordination (catching a ball)	□	□ Knowing left and right
□	□ Putting on shoes (velcro closure)	□	□ Holding a crayon or pencil
□	□ Tying shoe laces	□	□ Accidentally dropping things
□	□ Dressing self	□	□ Knowing where the body is in space
□	□ Buttoning and zipping	□	□ Trouble with balance or "clumsy"
□	□ Running	□	□ Seeks out wrestling, rough play frequently
□	□ Jumping	□	□ Avoids heights (play structure, stairs, etc.)
□	□ Riding a tricycle or bike	□	□ Avoids playing on the swings
□	□ Toileting accidents	□	□ Trouble telling time, or time awareness
□	□ Feeling when needs to go to the bathroom	□	□ Motor skills aren't even / symmetrical
□	□ Spins, rocks, paces, or other movements	□	□ Repeats words or phrases, or "echoes" others
□	□ Other repetitive motor movements	□	□ Uses phrases from tv/movies excessively
□	□ Stimming that helps with feeling calm	□	□ "Black and white" or literal thinking
□	□ Trouble talking about their day	□	□ Trouble understanding humor or sarcasm
□	□ When upset, has a lot of trouble communicating	□	□ Trouble following a conversation
□	□ Eye contact is less frequent than expected	□	□ Communicates best with adults or family
□	□ Does not pick up on typical social cues	□	□ Debates meanings of words
□	□ Has a hard time understanding body language	□	□ Rarely shares interests or accomplishments
□	□ Has trouble following multi-step directions	□	□ Dislikes social chit chat ("it's boring")
□	□ Articulation trouble or hard to understand	□	□ Enjoys conversations about favorite topics

Any other differences or concerns with communication skills, motor skills, or early development (see the next page for additional behavioral/emotional factors): _____

_____

_____

_____

_____

_____

Behavior / Emotions / Experiences: Please check below the items describing the client *compared to most other people of the same age.* For example, if the client has more organizational trouble than co-workers, then check the box "disorganized." If the client has more trouble concentrating than classmates, check "poor concentration."

Past Month	**Up to age 5 or 6 years old**	
□	□	Fidgets, has a hard time staying seated
□	□	Has difficulty waiting for their turn
□	□	Talks excessively, interrupts often
□	□	Poor concentration or daydreams too much
□	□	Eye contact is difficult or less frequent
□	□	Often loses things
□	□	Disorganized
□	□	Difficulty making decisions
□	□	Needs lots of prompts to do things
□	□	Difficulty initiating or completing tasks
□	□	Difficulty following instructions
□	□	Trouble with time management
□	□	Impulsive
□	□	Hyperactive, "driven by a motor"
□	□	Often argumentative
□	□	Blames others for own mistakes
□	□	Defiant to authority figures or rules
□	□	Talks to authority figures like a peer
□	□	Has been teased or bulled by others
□	□	Teases or bullies others
□	□	Lies or steals (circle)
□	□	Sets fires or fascinated by fire (circle)
□	□	Cruel toward animals
□	□	Physically or verbally aggressive (circle)
□	□	Doesn't have age typical stranger danger
□	□	Wanders off or elopes (runs away)
□	□	Problems with social interactions
□	□	Masks or hides true self in social settings
□	□	Feels disconnected from others
□	□	Would like more friends
□	□	Immature compared to others the same age
□	□	Avoids new activities or foods
□	□	Transitions are difficult
□	□	Does not like changes or new routines
□	□	Trouble playing imaginatively / "pretend"

Past Month	**Up to age 5 or 6 years old**	
□	□	Often depressed
□	□	Often irritable, frustrated, or agitated
□	□	Mood swings
□	□	Explosive temper
□	□	Crying easily or frequently
□	□	Feelings of worthlessness or low self-esteem
□	□	Avoiding spending time w/ family, friends (circle)
□	□	Hopelessness or feeling like there is no point to life
□	□	Has hurt self on purpose (cutting, scratching)
□	□	Suicidal thoughts or actions (circle)
□	□	Low energy/fatigue
□	□	Sleeping too little / too much (circle)
□	□	Poor appetite, picky eating, or overeating (circle)
□	□	Lots of physical complaints (stomach aches, headaches)
□	□	Feels stressed out, overwhelmed, or overworked
□	□	Anxious or worried
□	□	Panic attacks
□	□	Specific fears (crowds, heights, objects, future events)
□	□	Excessive difficulties separating from others/caregivers
□	□	Frequently wants to stay home from school/work
□	□	Saying the same thing over and over
□	□	Obsessions (can't stop thinking about something)
□	□	Compulsions (can't stop doing something)
□	□	Excessive interest in certain topics/activities
□	□	Interests that other people find very unusual
□	□	Interests seem too limited, or would like more interests
□	□	Does not like large groups of people
□	□	Overly sensitive to sound or light (circle)
□	□	Overly sensitive to touch, texture, clothes
□	□	Overly sensitive to certain tastes/food textures
□	□	Gets too close to others or in to people's "space"
□	□	Excessively low or high pain tolerance (circle)
□	□	Sensory seeking (touch, sound, etc.)
□	□	Uses electronics too much
□		(For adults) Sexual problems or concerns

Home life: What responsibilities/chores does the client have at home? Does it seem like too much / too little / just right? How does the client respond to limits/rules/supervisors/teachers/professors?

The client's personality and relationships: Is the client a leader or follower? Gets along well with family? Solid friendships? General mood?

Self-Advocacy: Does the client ask for help when needed and speak up about their needs?

Gender Identity and Expression, Sexual Orientation: Is there anything you would like Dr. Ferguson to know about the client's gender identity, gender expression, sexual orientation, or gender affirmative health care? Are family or loved ones supportive?

What is important for the client feel their best? This could be sensory or fidget items, predictable routine vs. change and new experiences, time alone vs. time with others, etc.

If the client is here for assessment, what are the experiences or behaviors that lead you to consider this? For example, if Autism, ADHD, anxiety, etc. feels like a fit for the client, why is that? Add as many pages as needed to discuss this if you like:

Anything Else You Would Like Dr. Ferguson to know? □ Nope □ This form was too long! □ This form was a good length and I liked having space to talk about all the things on my mind □ I have more to say (add pages!)

Person completing this form: Relationship to Client: □ Self □ Parent □ Guardian □ Conservator □ Other: _____

Signature **Name** **Date**